Patient Registration Form

OPHTHALMOLOGY associates

PATIENT INFORMATION:

Last Name:	First Name:	MI:	Birth Date:

Address:	City:	State:	Zip:

Home Phone:	Cell Phone:

Email Address:	Age:	Sex ❑ M ❑ F	Social Security #

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced	Employer:	Employer Phone:

Spouse's Name:	Phone Number:

PLEASE COMPLETE IF PATIENT IS UNDER AGE 18 OR A COLLEGE STUDENT:

Father's Last Name:	Father's First Name:	MI:	Father's Birth Date:

Father's Address:	City:	State:	Zip:

Father's Home Phone:	Father's Cell Phone:	Fathers' Social Security #:

Mother's Last Name:	Mother's First Name:	MI:	Mother's Birth Date:

Mother's Address:	City:	State:	Zip:

Mother's Home Phone:	Mother's Cell Phone:	Mother's Social Security #:

REFERRAL INFORMATION:

Name of Family Physician:	Name of Optometrist:

How did you hear about our office: ☐ KMOX w/Charlie Brennan ☐ KYKY w/Jen Myers ☐ KMOX w/Rick Wallace

☐ KMOX w/Chris Hrabe ☐ Radio ☐ KEZK w/Trish Gazzel ☐ KLOU w/Julie Tristan ☐ Website ☐ Television Ad

☐ Doctor Referral ☐ Friend or Family ☐ Other _____

(Please complete back side)

12990 Manchester Road • Suite 200 • Des Peres, Missouri 63131
Office: (314) 966-5000 • After Hours: (314) 388-5354 • Facsimile: (314) 909-6666

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PRIMARY INSURANCE	
Name of Insurance:	ID Number:
Employer:	Group Number:
Who is the subscriber:	Do you need a referral?: ❑ Yes ❑ No
Subscriber's Date of Birth:	Subscriber's Social Security #:

SECONDARY INSURANCE	
Name of Insurance:	ID Number:
Employer:	Group Number:
Who is the subscriber:	Do you need a referral?: ❑ Yes ❑ No
Subscriber's Date of Birth:	Subscriber's Social Security #:

This is to certify that, I the undersigned, consent to examination and treatment. This information and any photography may be used for scientific and educational purposes. I hereby authorize Ophthalmology Associates to furnish information to my insurance carrier, employer, referring physician, or other physician concerning my treatment and/or illness. I transfer all assignment of all insurance benefits to Ophthalmology Associates for services, treatment, supplies or surgeries provided by physicians or staff. **I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE. IF I DO NOT PAY MY BILL I UNDERSTAND THAT I AM RESPONSIBLE AND AGREE TO PAY ALL FEES, INCLUDING COLLECTION FEES OF 30% OF TOTAL BALANCE, ATTORNEY'S FEES AND COSTS OF COURT.**

Patient Signature: _____ **Date:** _____

If under 18, Parent/Guardian Signature: _____

Patient Name: _____ **Date of Birth:** _____

Today's Date: _____

Medical Information Form

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Patient's Name: _____ Birth Date: ____/____/____

Do you wear glasses or contact lenses? ❑ Yes ❑ No If Yes, for how long? _____

Please ✓ if any of the following apply to you and the date it first occurred:

MEDICAL PROBLEMS

Condition	Please ✓	Date
Alzheimer's	❑ Yes ❑ No	
Arthritis	❑ Yes ❑ No	
Asthma/COPD/Bronchitis	❑ Yes ❑ No	
Cancer – type _____	❑ Yes ❑ No	
Diabetes – type _____	❑ Yes ❑ No	
High blood pressure	❑ Yes ❑ No	
Hepatitis/Jaundice	❑ Yes ❑ No	
Heart Disease	❑ Yes ❑ No	
Head Injury	❑ Yes ❑ No	
HIV positive/AIDS	❑ Yes ❑ No	
Kidney Disease	❑ Yes ❑ No	
Lupus	❑ Yes ❑ No	
Migraine Headaches	❑ Yes ❑ No	

Condition	Please ✓	Date
Rheumatic Fever	❑ Yes ❑ No	
Sarcoidosis	❑ Yes ❑ No	
Seizures	❑ Yes ❑ No	
Stroke	❑ Yes ❑ No	
Syphilis / Gonorrhea	❑ Yes ❑ No	
Thyroid Disease	❑ Yes ❑ No	
Tuberculosis	❑ Yes ❑ No	

Other Medical Problems (Please List)

_____

_____

_____

_____

SURGICAL HISTORY

Have you had **general** surgery? ❑ Yes ❑ No

Please list:

Surgery	Date	Surgeon/Hospital

Have you had **eye** surgery? ❑ Yes ❑ No

Please list (including laser and lid surgery):

Surgery	Date	Surgeon/Hospital

MEDICATIONS *(Please List)*

May we access your medications from our electronic prescription service? ❑ Yes ❑ No

Name	Dosage

Are you allergic to any medications, iodine, latex or anesthesia?

❑ Yes ❑ No If ***yes***, please list below:

_____

Do you require antibiotics prior to surgery?

❑ Yes ❑ No

Height: _____ **Weight:** _____

BP: _____

FAMILY MEDICAL PROBLEMS

Do any family members have:	Please ✓	Relative
Glaucoma	❑ Yes ❑ No	
Macular Degeneration	❑ Yes ❑ No	
Diabetes	❑ Yes ❑ No	
Retinal Detachment	❑ Yes ❑ No	
Cataracts	❑ Yes ❑ No	
Amblyopia/Strabismus	❑ Yes ❑ No	

Other (list): _____

SOCIAL HISTORY

Tobacco Use:		
❑ Yes	❑ Every Day	❑ Some Days
❑ No	❑ Former Smoker	❑ Never Smoked
Alcohol Use:		
❑ Yes	❑ Current	
❑ No	❑ Former	❑ Never

Are you pregnant?	❑ Yes ❑ No
Do you drink alcohol?	❑ Yes ❑ No
Do you drink caffeine?	❑ Yes ❑ No
Do you use illegal drugs?	❑ Yes ❑ No

Medical Review Of Systems

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Patient Name _____ Birth Date _____

DO YOU CURRENTLY HAVE ANY PROBLEMS IN THE FOLLOWING AREAS?

Check ☑ Yes boxes only. No need to check ❑ No boxes.

CONSTITUTIONAL		
Fatigue	❑ Yes	❑ No
Malaise	❑ Yes	❑ No
Chills	❑ Yes	❑ No
Fever	❑ Yes	❑ No
Night Sweats	❑ Yes	❑ No
Appetite Changes	❑ Yes	❑ No
Weight Changes	❑ Yes	❑ No

HEENT		
Head Injury	❑ Yes	❑ No
Decreased Hearing	❑ Yes	❑ No
Tinnitus	❑ Yes	❑ No
Earache	❑ Yes	❑ No
Hay Fever	❑ Yes	❑ No
Sinus Pain	❑ Yes	❑ No
Stuffiness	❑ Yes	❑ No
Discharge	❑ Yes	❑ No
Dry Mouth	❑ Yes	❑ No
Sore Throat	❑ Yes	❑ No
Dentures	❑ Yes	❑ No
Difficulty Swallowing	❑ Yes	❑ No
Vertigo	❑ Yes	❑ No
Seasonal Allergies	❑ Yes	❑ No

CARDIOVASCULAR		
Angina	❑ Yes	❑ No
Heart Attack	❑ Yes	❑ No
High Cholesterol	❑ Yes	❑ No
High BP	❑ Yes	❑ No
Low BP	❑ Yes	❑ No
Murmur	❑ Yes	❑ No
Thrombophlebitis	❑ Yes	❑ No
Varicose Veins	❑ Yes	❑ No
Atrial Fibrillation	❑ Yes	❑ No

RESPIRATORY		
COPD	❑ Yes	❑ No
Wheezing	❑ Yes	❑ No
Cough	❑ Yes	❑ No
Hemoptysis	❑ Yes	❑ No

RESPIRATORY CONT.		
Asthma	❑ Yes	❑ No
Tuberculosis	❑ Yes	❑ No
Shortness of Breath	❑ Yes	❑ No

GASTROINTESTINAL		
Diarrhea	❑ Yes	❑ No
Constipation	❑ Yes	❑ No
Stool Changes	❑ Yes	❑ No
Hemorrhoids	❑ Yes	❑ No
Indigestion	❑ Yes	❑ No
Difficulty Swallowing	❑ Yes	❑ No
Nausea/Vomiting	❑ Yes	❑ No
Acid Reflux	❑ Yes	❑ No

GENITOURINARY		
Prostate Cancer	❑ Yes	❑ No
Difficult Urination	❑ Yes	❑ No
Enlarged Prostate	❑ Yes	❑ No
Increased Frequency	❑ Yes	❑ No
Frequent UTIs	❑ Yes	❑ No
Incontinence	❑ Yes	❑ No
Kidney Stones	❑ Yes	❑ No

DERMATOLOGICAL		
Rash	❑ Yes	❑ No
Lump	❑ Yes	❑ No
Itching	❑ Yes	❑ No
Dryness	❑ Yes	❑ No
Rosacea	❑ Yes	❑ No

MUSCULOSKELETAL		
Arthritis	❑ Yes	❑ No
Swelling	❑ Yes	❑ No
Stiffness	❑ Yes	❑ No
Muscle Aches	❑ Yes	❑ No
Muscle Weakness	❑ Yes	❑ No
Leg Cramps	❑ Yes	❑ No
Back Pain	❑ Yes	❑ No
Joint Pain	❑ Yes	❑ No
Rheumatoid Arthritis	❑ Yes	❑ No

PSYCHIATRIC		
Depression	❑ Yes	❑ No
Nervousness	❑ Yes	❑ No
Anxiety	❑ Yes	❑ No
Memory Loss	❑ Yes	❑ No
Panic Attacks	❑ Yes	❑ No
Mania	❑ Yes	❑ No

ENDOCRINE		
Polydipsia	❑ Yes	❑ No
Hypoglycemia	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No
Hypothyroid	❑ Yes	❑ No
Hyperthyroid	❑ Yes	❑ No
Goiter	❑ Yes	❑ No
Heat/Cold Intolerance	❑ Yes	❑ No
Graves' Disease	❑ Yes	❑ No

HEMATOLOGIC		
Ease of Bruising	❑ Yes	❑ No
Excessive Bleeding	❑ Yes	❑ No
Enlarged Lymph Nodes	❑ Yes	❑ No
Anemia	❑ Yes	❑ No

NEUROLOGICAL		
Alzheimer's	❑ Yes	❑ No
Dizziness	❑ Yes	❑ No
Headaches	❑ Yes	❑ No
Migraines	❑ Yes	❑ No
Multiple Sclerosis	❑ Yes	❑ No
Neuropathy	❑ Yes	❑ No
Paralysis	❑ Yes	❑ No
Parkinson's Disease	❑ Yes	❑ No
Seizures	❑ Yes	❑ No
Stroke	❑ Yes	❑ No
TIA	❑ Yes	❑ No
Tremors	❑ Yes	❑ No

Additional Notes/Comments:

Privacy Notice / Authorization To Release Information

OPHTHALMOLOGY associates

To All Patients

I _____ , acknowledge that:

- I have been given the opportunity to review the Notice of Privacy Practice of Ophthalmology Associates. The policy can be reviewed at any time by visiting www.youreyedoc.comhtt

I hereby authorize Ophthalmology Associates to:

- Administer medical treatment as is necessary for a patient in my condition.
- Release any and all information contained in my medical records pertaining to this treatment or series of treatments to my insurance company, third party carriers, or their representatives, and referring or consulting physicians.
- Authorized payments of medical and surgical benefits, provided by my insurance carrier, to Ophthalmology Associates.
- View and share my prescription drug RX's electronically. This will allow Ophthalmology Associates to view all my drug prescriptions that other doctors have prescribed for me as this also gives other doctors the ability to view (upon my consent) what the physicians at Ophthalmology Associates have prescribed to me. This will help all my prescribing doctors to have a current, active medication list to help with the future orders of medications, and drug-to-drug interactions.

Medicare Patients:

In Medicare assigned cases, the physician agrees to accept the charge determination of the fiscal intermediary as the full charge. I understand that I am responsible for the deductible, co-insurance, and non-covered services. Co-insurance and deductibles are based upon charge determination of the Medicare carrier if this is less than the charge submitted. Therefore, I request that payment of authorized Medicare benefits be made to me or on my behalf to Ophthalmology Associates for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and it's agents any information needed to determine these benefits or the benefits payable for related services.

This form does not authorize any above named person to make health care decisions for the above named patient, or entitle them to paper or electronic copies of the patient's medical records. We will not release via telephone, or any other means of communication any information to any friends or family members not listed unless the patient has an opportunity to object and does not (via documentation) or it is reasonable to infer that the patient does not object such as when a patient brings a spouse into the exam room when treatment is discussed. Exception: If the release is needed in an emergency situation.

Signature: _____ Date: _____

(See back side →)

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Patient Name:_____ Date of Birth:_____

In accordance with Health Care Reform (effective 10/1/2012), we are required to ask the following questions for gathering purposes only. The answers have no bearing on your care as our patient.

Preferred Language: _____

Ethnicity

- ☐ Hispanic / Latino
- ☐ Not Hispanic / Latino
- ☐ Decline to answer

Race: (please check all that apply)

- ☐ American Indian / Alaska Native
- ☐ Asian
- ☐ Black / African American
- ☐ White / Caucasian
- ☐ Native Hawaiian / Pacific Islander
- ☐ Other
- ☐ Decline to Answer

Preference for Communication

☐ Home
- ➢ If you are unavailable, may we leave a message:
  - ○ With another person
  - ○ On a voice mail or answering machine

☐ Cell
- ➢ If you are unavailable, may we leave a message:
  - ○ Text message
  - ○ On a voice mail or answering machine

☐ Work
- ➢ If you are unavailable, may we leave a message:
  - ○ With another person
  - ○ On a voice mail or answering machine

☐ Email

I, _____ , hereby authorize release of my Protected Health information for discussion of my care or treatment to the person(s) specified below. Authorized family member or person to receive **verbal** information for the above name patient's care:

Name:_____Relationship:_____ Phone: _____

Name:_____Relationship:_____ Phone: _____

- Note: This form does not give the above referenced persons permission to make health care decisions for the patient or entitle them to paper or electronic copies of the patient's medical record. We will not release via the telephone or any means of communication any information to any friends or family members not listed above unless the patient has an opportunity to object and does not (documented) or if it is reasonable to infer that the patient does not object such as when a patient brings a spouse into the room when treatment is being discussed. Exception: If the release is needed in emergency situations.

Printed Name of Patient or Legal Personal Representative: _____

Signature: _____ Date:_____

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LIFESTYLE VISION QUESTIONNAIRE

Name: _____ **Date** _____

We recognize that your eyes are very important to you. We would like to know how *you* use your eyes on a daily basis. Along with your eye exam, this info will assist us in recommending the best options for your eyes and your personal lifestyle vision.

- Do you wear glasses now? ❑ No ❑ Yes
  If Yes, how often? ❑ All the time ❑ Sometimes
  ❑ Only for distance ❑ Only for reading ❑ Only for computer
- How important is it for you to see to read or use computer without glasses?
  ❑ Very important ❑ Important ❑ Somewhat important ❑ Not important
- If it were possible to go without glasses for most of the time, would you like that?
  ❑ No ❑ Yes
- How many hours per day do you: Read?_____ hrs Use computer?_____ hrs
- Do you drive at night? ❑ Socially ❑ Occasionally ❑ Often

CHECK the following activities you do on a regular basis:

❑ Read books	❑ Play Cards / Dominos	❑ Drive daytime
❑ Read medicine bottles	❑ Paint / Artist	❑ Drive nighttime
❑ Needlepoint / Crochet	❑ Cook	❑ Golf
❑ Dine in Restaurant	❑ Musician	❑ Hunt / Fish
❑ Shopping	❑ Computer / Tablet	❑ Bicycling, Hiking etc.
❑ Photography	❑ Cell phone	❑ Tennis
❑ Other _____		❑ Spectator Sports

Please circle on the following scale to describe your personality as best you can:

1 2 3 4 5 6 7 8 9 10

Easy going Perfectionist